clinical trials carried out for dermatological and rheumatological diseases describe exacerbations or new cases of inflammatory bowel disease (IBD), with a low incidence of 0.7 per 100 patient-years in patients with AS. We present a case series of patients who developed new onset severe colitis after the commencement of Secukinumab for the treatment of AS.

**Discussion**

These cases present the association between the use of biologics and inflammatory bowel disease. 2 of 3 patients started on Adalimumab whilst the other received IV steroids alone. One of the patients was treated with infliximab. No case had evidence of infection. Endoscopic examination for the 2 patients showed severe colitis. The patient with pouch did not have an endoscopy. Histology for the 2 cases confirmed severe active colitis of idiopathic nature. All three cases received steroids and Secukinumab was stopped. The patient with pouchitis responded to oral steroids alone. One of the patients was started on Adalimumab whilst the other received IV steroids and ciclosporin as the initial response to steroids was poor.

**Results**

All 3 patients were male and presented from July 2018 to July 2019. The mean age was 57.33 years. One case had a subtotal colectomy for Ulcerative Colitis 10 years ago with pouch formation. 2 patients had received Adalimumab for AS in the past and one was treated with infliximab. No case had evidence of infection. Endoscopic examination for the 2 patients showed severe colitis. The patient with pouch did not have an endoscopy. Histology for the 2 cases confirmed severe active colitis of idiopathic nature. All three cases received steroids and Secukinumab was stopped. The patient with pouchitis responded to oral steroids alone. One of the patients was started on Adalimumab whilst the other received IV steroids and ciclosporin as the initial response to steroids was poor.

**Discussion**

These cases present the association between the initiation of Secukinumab therapy and the development of severe colitis. Though there are no formal guidelines on the management of such cases, our patients responded to other biological and non-biological agents with rapid resolution. Clinicians should be aware of the association between this IL-17 antagonist and the development of severe colitis and prescribers should evaluate individual risk factors prior to its commencement with close monitoring. The pathogenesis behind this is not fully understood and requires further research.

**Abstract P164 Table 1**

<table>
<thead>
<tr>
<th>Variables, r (p-value)</th>
<th>BL 2-Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCCAI (physician) vs. P-SCCAI</td>
<td>0.86 (&lt;0.0001) n=62</td>
</tr>
<tr>
<td>SCCAI (physician) vs. PRISM (physician)</td>
<td>-0.64 (&lt;0.0001) n=63</td>
</tr>
<tr>
<td>PRISM (patient) vs. PRISM (physician)</td>
<td>0.67 (&lt;0.0001) n=63</td>
</tr>
<tr>
<td>PRISM (patient) vs. SIBDQ</td>
<td>0.71 (&lt;0.0001) n=63</td>
</tr>
<tr>
<td>PRISM (patient) vs. PHQ-9</td>
<td>-0.56 (&lt;0.0001) n=63</td>
</tr>
<tr>
<td>PRISM (patient) vs. P-SCCAI</td>
<td>-0.58 (&lt;0.0001) n=62</td>
</tr>
</tbody>
</table>

**Abstract P165**

**DISEASE-RELATED WORRIES AND CONCERNS IN UK PATIENTS WITH ULCERATIVE COLITIS: 2-YEAR DATA FROM ICONIC**

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**Introduction**

ICONIC is the largest prospective, multi-country observational study assessing cumulative disease-associated burden in adults with ulcerative colitis (UC) under routine care. This local subanalysis evaluated patient worries and concerns over 2 years in UK patients using the Rating Form of Inflammatory Bowel Disease (IBD) Patient Concerns (RFIPC) questionnaire.

**Methods**

Adults with early UC (diagnosed ≤36 months) were included irrespective of treatment regimen/disease assessments of disease activity/impact included: disease severity, Pictorial Representation of Illness and Self-Measure (PRISM, a measure of perceived disease impact; lower scores=greater burden); Patient Health Questionnaire-9 (PHQ-9); Short Inflammatory Bowel Disease Questionnaire (SIBDQ); patient-modified Simple Clinical Colitis Activity Index (P-SCCAI).

Physician assessments included: clinical parameters; PRISM; SCCAI. Correlations between measures were assessed using Spearman’s correlations.

**Results**

63 patients were included (59% female; mean age 43 years; median time since diagnosis 126 days); 98% patients received treatment post-diagnosis. Physician-assessed baseline (BL) severity was: in remission 16 (25%), mild 18 (29%), moderate 18 (29%), severe 11 (17%). Overall, 48% patients agreed with physician-assessed severity (remission 50%, mild 68%, moderate 28%, severe 46%). Table 1 shows correlation coefficients between measures at BL and 2-years. At 2-years, mean±SD P-SCCAI/physician SCCAI scores were 2.6±2.6 and 1.5±1.5; patient and physician PRISM scores were 5.2±2.6 and 5.2±2.1.

**Conclusion**

Persistently high UC burden was observed over 2 years, despite treatment. PRISM, used for the first time in UC, was moderately correlated with disease-specific (SIBDQ/SCCAI) and general depression (PHQ-9) measures. Alignment between patients and physicians on disease activity/severity varied but was greatest for SCCAI.
severity. Patients completed RFIPC (a 25-item questionnaire about frequently reported worries/concerns in IBD) at each visit (6-month intervals). Responses are scored on a 10-cm visual analogue scale (0 = ‘no concerns’ to 10 = ‘a great deal’; total score=mean of all items). Data are reported using descriptive statistics at baseline (BL, visit 1 [V1]), 1-year (V3), and 2-years (V5) and scores stratified by physician-assessed disease severity (in remission, mild, moderate, severe) at BL.

Results 63 patients were included (37 [59%] female; mean ±SD age 43.4±15.7 years; median time since diagnosis 126 days; physician-assessed severity: in remission 16 [25%], mild 18 [29%], moderate 18 [29%], severe 11 [17%]). Mean±SD total RFIPC scores for all patients were 2.9±2.3 (n=63) at V1, 2.7±2.5 (n=40) at V3, and 2.2±2.0 (n=35) at V5. At BL, mean±SD RFIPC total scores by disease severity were: in remission 1.8±1.7, mild 3.2±1.9; moderate 2.6±2.6; severe 4.8±2.4. The changes from BL to V5, stratified by disease severity at BL, were: in remission -0.2±1.0, mild -1.2±1.4; moderate -0.7±1.7; severe -2.2±2.7. The specific concerns with the highest scores (mean RFIPC score >4.0) at BL were ‘energy level’, ‘having an ostomy bag’ and ‘effects of medication’; the mean total scores for these items decreased between V1 and V5 for all patients. Of 5 UK sites, all had established multidisciplinary teams (MDTs) and 4 had a psychologist in situ.

Conclusion Despite all centres having MDTs and most having on-site psychologists, this subanalysis from ICONIC demonstrated a high burden of worries and concerns in early UC patients with more severe disease. Concerns were most notable at BL, appearing to decrease over time. The greatest concerns were with treatment and complications of UC, including energy levels, indicating fatigue remains an unmet need for UC patients.

P167 RULING OUT INFLAMMATORY BOWEL DISEASE WITH Faecal calprotectin: THE SOUTH AND WEST DEVON EXPERIENCE

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10.1136/gutjnl-2020-bsgcampus.242

Introduction Faecal calprotectin (FC) testing in UK primary care is informing the diagnostic process where inflammatory bowel disease (IBD) is suspected but functional disease is likely (irritable bowel syndromes, IBS). Uptake of the regional IBD/IBS clinical pathway prompted laboratory adoption of an assay platform (Phadia 250 ELIA; ThermoFisher Scientific) offering more suitable batch sizes and facile sample preparation compared with ELISA while delivering similar analytical precision and range. Eighteen months later, comparison is made of FC diagnostic performance in the regional population vs published data, the clinical decision limit is reviewed and useful audit criteria established.

Methods Retrospective analysis of FC results (μg/g stool); analytical range 4–6000 μg/g; imprecision [2xCV] 12% at 20μg/g, 17% at 198μg/g diagnostics reports and gastroenterology clinic letters. Letters were reviewed for all patients with results ≥100μg/g or ≥3 tests. Inclusion criteria: primary care patients 18.0–46.0y when tested, March 2018-November 2019. Exclusion criteria: known IBD, incomplete results or follow-up. Outcome measure: IBD diagnosis.

Results 2,962 FC results considered from 2,771 patients; of those with multiple results, 99% had only one repeat. 75% of tests in age range 1,741 eligible results with complete follow-up. At 100 μg/g (95% CI) PPV 36% (32–40%); NPV 100% (93–100%); sensitivity 95% (88–100%) specificity 92% (85–99%); ROC AUC 0.970 (0.957–0.982). IBD prevalence 4.1%. One false negative identified (isolated ileal Crohn’s revealed by video capsule endoscopy.) 191 results 46–99 μg/g indicated repeat; 27% repeated, 60% normalized withdrawal of concomitant therapy (including steroids), CRP and adverse events.

Results 166 LDAA and 118 AZAm patients (≥ 90% having active disease) were included with a median follow-up of 25 and 27 months, respectively. Clinical benefit was higher in the LDAA cohort at both 6 months (74% vs 53%, p=0.0004) and 12 months (54% vs 37%, p=0.01). The overall median duration of beneficial response since commencement of therapy was 17 months (95%-CI 9 – 25) for LDAA therapy compared to 6 months (95%-CI 1 – 11) for AZAm. The lower efficacy of AZAm was explained by the median dose tolerated of 1.83 mg/kg (73% of most effective dose) and high percentage (45%) of patients discontinuing due to intolerance. Although elevated liver function tests and leukopenia were relatively common observed in the LDAA cohort, they only led to treatment withdrawal in 2% for both. Increasing allopurinol dosage from 100 to 200 – 300 mg/day significantly lowered liver enzymes in the majority (83%) of patients who had developed hepatotoxicity on LDAA.

Conclusions Optimisation of AZA therapy for IBD is mandatory as poor outcomes were observed in our AZAm cohort. LDAA without metabolite monitoring should be considered standard first-line immunosuppressive therapy, as we demonstrated a safe and effective profile in the long-term.

P166 FIRST-LINE AZATHIOPRINE- ALLOPURINOL WITHOUT METABOLITE MONITORING IS AN EFFECTIVE AND SAFE LONG-TERM THERAPY FOR IBD

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10.1136/gutjnl-2020-bsgcampus.241

Introduction The number of IBD patients experiencing a beneficial response from the first-line, low-cost immunosuppressive azathioprine (AZA) is too low due to high rates of adverse events. Co-administration with allopurinol has been reported to improve tolerability and might be an option as first-line therapy.

Methods The long-term efficacy, side-effects and safety of low-dose azathioprine with allopurinol (LDAA) was compared with AZA monotherapy (AZAm) in thiopurine-naïve IBD patients unguided by metabolite levels. Medical records of patients (identified from pharmacy dispensing records and an IBD database) were reviewed retrospectively. The primary outcome ‘clinical benefit’ was defined as: ongoing use of therapy without initiation of steroids, biologics or IBD-surgery. Secondary outcomes included disease activity scores, endoscopic findings,